Please check one:
( ) New Application

( ) Renewal Application
*If renewal please add:
Certificate #_____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING & REGULATORY SERVICES

APPLICATION FOR A CERTIFICATE TO OPERATE A HOME DAY CARE

Please complete the following application for Home child Care Certification and return it with a check or money order made payable to TREASURER, STATE OF MAINE. The $40.00 application fee is non-refundable. Mail to:

Department of Health and Human Services
Division of Licensing & Regulatory Services
Community Services Programs
41 Anthony Avenue, 11 State House Station
Augusta, ME 04333-0011

Applicant

Print/Type Name: _____Name of Facility:_____Birth Date:_____

Any Former Names: _____Social Security or IRS Number: _____

Street Address: _____ P.O. Box _____

Town: _____Zip code: _____ E-mail:_____

Town of Residence: _____Telephone: _____

DAY CARE FAMILY:

Members of Household Other Than Day Care Provider:

Name	Birth Date	Social Security #	Relationship to Applicant

(Use additional sheet of paper if necessary)

- FOR OFFICE USE ONLY –

LICENSING WORKER: _____ FULL ( ) PROV ( ) TEMP ( )

CAPACITY: _____ EFFECTIVE: _____ EXPIRES: _____
INSPECTION DATE: _____ ID#: _____

SOURCE OF WATER (CHECK ONE): MUNICIPAL ( ) PRIVATE ( )

( ) CHECK HERE IF YOU WOULD LIKE A WATER TEST KIT MAILED TO YOU. ( ) SIGNED BOTTLED WATER AGREEMENT ON FILE

What Year Was Your Home Built? _____

Directions to the Home: (Be specific and as detailed as possible. No maps please)

_____
_____
_____
_____
_____
_____

Best time of day to visit: _____

Largest Number of Children to be in your care at any time:
(You are not required to count your own children).

3 – 6 ( ) 7 – 12 ( )

Names, Addresses and Phone Numbers of All People Working with Children: (Use additional sheet of paper if necessary.)

Name: _____ SS# _____ Telephone: _____

Address: _____ Town: _____

Name: _____ SS# _____ Telephone: _____

Address: _____ Town: _____

Other Licenses:

Are you now, or have you ever been licensed, registered or certified to provide services for children or adults? Yes ( ) No ( )

If yes, please indicate the type of care, approximate dates of service and name(s) under which you were licensed:

_____
_____
_____

Have you had any prior sanctions such as a conditional certificate, certificate suspension, fine or revocation regarding a child or adult care certificate or approval issued to you? ( ) Yes ( ) No If Yes, please explain:

_____
_____
_____
_____

YOUR HISOTRY: Please use additional sheets of paper if necessary to explain your responses to these questions. Have you or has anyone employed by you or living in or frequenting your home been involved in the following:

1) Convicted of a crime; ( ) Yes ( ) No
2) Involved in a child protective investigation; ( ) Yes ( ) No
3) Named as a defendant in a Protection from Abuse Order; ( ) Yes ( ) No
4) Had children removed from their care or custody by court order. ( ) Yes ( ) No
5) If you are a renewal applicant, have you had any of the above in the last year? ( ) Yes ( ) No

If you checked yes to any of the above, please explain:

_____

_____

_____

Have you ever been treated for drug or alcohol abuse? Yes ( ) No ( )
If yes, please explain: _____

_____

Have you ever received mental health services? Yes ( ) No ( ) If yes, please explain:

_____

_____

Is there any other information that would be useful in assessing your ability to provide care for children?

Yes ( ) No ( ) If yes, please explain:

_____

_____

_____

I/We have received and read the "Rules for Home Day Care Providers". I/We understand that this application authorizes representatives of the Department and the State Fire Marshall's Office to make such visits and inspections as may be necessary to ascertain that the facility is in compliance with the LAW and RULES pertaining to the operation of such facilities.

I/We further certify that all information contained in this application is complete and accurate. I/We understand that misrepresentation may be cause for denial or revocation of my Home Day Care Certificate.

Applicant's Signature: _____ Date: _____

Co-Applicant's Signature: _____ Date: _____

AUTORIZATION FOR THE RELEASE OF PERSONAL HISOTRY INFORMATION FOR ALL ADULT MEMBERS OF HOUSEHOLD/STAFF

By signing below, I authorize the release of confidential records or information regarding any **criminal record, child protection record or motor vehicle record** to the Department of Health and Human Services, Division of Licensing and Regulatory Services, Community Services Programs.

I understand that any information obtained as a result of this release of information will remain confidential, as required by law, and will be used solely for the purpose of determining whether a license or approval to operate a children's daycare or other license should be granted or renewed.

Also, if any criminal record, child protection record or motor vehicle record indicates that a prior conviction or finding exists, the applicant will need to provide evidence to the Division of Licensing and Regulatory Services that any prior history has been addressed and the individual will not compromise or threaten the safety of any children to be cared for by the applicant.

This consent may be revoked by me, in writing , at any time, except that information that has already been obtained.

I understand that each adult member of my household or staff/volunteers must complete the lower portion of this form and that failure to do so will invalidate my application.

For adult household members and staff/volunteers: By signing below, adult household members and staff/volunteers authorize the Department of Health and Human Services, Division of Licensing & Regulatory services to disclose confidential records or information regarding that person's criminal, child protection, or motor vehicle record to the applicant/provider.

Please sign this form and return it to: Department of Health and Human Services, Division of Licensing & Regulatory Services, Community Services Programs, 41 Anthony Avenue, SHS #11, Augusta, ME 04333-0011. Without this signed release, the application cannot be approved and the applicant will be denied permission to operate.

Provider's Information

Provider's Full Name: _____Former/Maiden names: _____
Street Address: _____Telephone: _____
City, State & Zip: _____Date of Birth: _____
Social Security #: _____ Signature: _____

Adult Household Members and Staff/Volunteers Information

Full Name: _____ Full Name: _____
Street Address: _____ Street Address: _____
City, State & Zip: _____ City, State & Zip: _____
Telephone #: _____ Telephone #: _____
Date of Birth: _____ Date of Birth: _____
Former/Maiden Names: _____ Former/Maiden Names: _____
Social Security #: _____ Social Security #: _____

Signature: _____ Signature: _____

Full Name: _____ Full Name: _____
Street Address: _____ Street Address: _____
City, State & Zip: _____ City, State & Zip: _____
Telephone #: _____ Telephone #: _____
Date of Birth: _____ Date of Birth: _____
Former/Maiden Names: _____ Former/Maiden Names: _____
Social Security #: _____ Social Security #: _____

Signature: _____ Signature: _____